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Correctional Staff Attitudes Toward Transgender Individuals

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Abstract

Compared to the general population, transgender individuals face higher rates of victimization, violence, substance use, physical health issues, and mental health problems. Transgender people are more likely to face barriers in finding and maintaining employment and housing due to discrimination. As a result, they are more likely to participate in illegal economies such as sex work and drug distribution. These factors contribute to the overrepresentation of transgender people in jails and prisons in the United States. Specifically, 16% of transgender adults have been incarcerated, compared to 2.7% of the general population. While under custody, transgender individuals are at risk of verbal, physical, and sexual abuse and harassment by correctional staff. Although past research has documented the experiences of transgender individuals who are incarcerated in correctional facilities, no study to date has examined correctional officers' experiences with the transgender population. As part of this proposed study, an online survey will be distributed to correctional staff at Denver's County Jails to measure attitudes toward transgender individuals. Results will be used to inform tailored interventions, such as staff training, to improve standards of care under custody.

Keywords: transgender, deputies, jail, prison, discrimination, healthcare, incarceration, corrections, providers

Introduction

In the United States, approximately 0.6% of adults, or 1.4 million individuals, identify as transgender (Flores et al., 2016). Transgender describes a person whose gender identity is different from their sex assigned at birth (National LGBT Health Education Center, 2020). Conversely, cisgender describes people whose gender identity and expression matches their sex assigned at birth. Although it is with increasing safety and acceptance that has allowed gender diverse people to express themselves more outwardly (Yarbrough, 2018), transgender people are subject to significant forms of discrimination and violence in the United States.

For a large part of the 20th century, transgender individuals were falsely viewed as deviant sexual offenders and/or accused of perversion and predatory sexual behavior (Dennis, 2014; Noga-Styron et al., 2012). In 1980, gender identity disorder appeared in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), which created a link between one's gender identity and mental illness. However, such claims are no longer supported today and in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), published in 2013, gender identity disorder was replaced with gender dysphoria (American Psychiatric Association [APA], 2013). Gender dysphoria is defined as, "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration" (APA, 2013, p. 452). The DSM-V further gave gender dysphoria its own chapter, separating it from Sexual Dysfunctions and Paraphilic Disorders. This diagnostic term aimed to protect access to treatment options for transgender people and prevent discrimination in social, occupational, and/or legal areas (APA, 2013).

For an individual to meet criteria for gender dysphoria, the incongruence must be associated with significant distress or impairment in function. One effective method to alleviate

said distress is to transition or live in a manner that is aligned with their gender identity. Individuals undergo several processes, including social (e.g., changing wardrobe or hairstyle, coming out to others), medical (e.g., hormones, gender affirmation surgery), and legal (e.g., changing gender marker and name on identity documents). A diagnosis of gender dysphoria is required by insurance companies in order to cover costs associated with gender affirmation surgery. The diagnosis, however, continues to be controversial because critics assert that distress associated with gender dysphoria is not caused by a problem within the individual, but because of society's disapproval of their identity and expression (Davy, 2015). Despite efforts within psychiatry and psychology to shift the narrative surrounding transgender individuals to promote acceptance, these historical labels continue to have political, financial, and medical ramifications (Baughey-Gill, 2011; Davy, 2015).

As previously stated, transgender individuals are commonly subject to discrimination, prejudice, violence, and stigma (Factor & Rothblum, 2008; Lombardi et al., 2001; White Hughto et al., 2015). Social stigma is described as an extreme disapproval of a person based on their personal or physical characteristics that single them out from others in society (Goffman, 1963). Social stigma contributes to inequities in employment and housing. In a study of 515 transgender people residing in the San Francisco area, 46% of transgender women reported employment discrimination, and 27% reported housing discrimination (Clements et al., 1999). Further, 57% of transgender men in the study reported employment discrimination and 20% reported housing discrimination. In a study of 252 transgender people in Washington, D.C., 15% reported job loss as a result of being transgender (Xavier et al., 2005). These challenges have resulted in higher rates of homelessness and unemployment compared to the general population, leading to poverty. Specifically transgender persons are four times more likely to have a household income

of less than $10,000 per year compared to the general population (Grant et al., 2011). As a result of the social stigma, a disproportionate number of transgender people participate in underground economies in order to survive, such as sex work or drug distribution (Bassichis, 2009; Weinberg et al., 1999).

Transgender individuals also face higher rates of verbal harassment, physical assault and sexual victimization (Grant et al., 2011). More specifically, almost half of all transgender people have been sexually assaulted at some point in their lives, and these rates are even higher for transgender people of color (James et al., 2016). Further, transgender individuals frequently experience violence, rejection and decreased support by their own families. According to the 2015 U.S. Transgender Survey (James et al., 2016), 10% of those who were out to their immediate family reported that a family member was violent towards them because they were transgender, and 8% were forced to leave their home because of their identity. In another large survey, 57% reported experiencing significant family rejection (Grant et al., 2011). Until 2009, when the Matthew Shepard and James Byrd Jr. Hate Crimes Prevention Act were passed, gender identity-biased violence and discrimination were not considered crimes of hate (Nadal, 2013).

Mental and Physical Health Outcomes

According to the Meyer (2003) minority stress model, social and economic disadvantages faced by transgender people exposes them to elevated and persistent levels of stress, which then results in adverse health outcomes (Gamarel et al., 2014; Rood et al., 2016). Given the regular discrimination transgender people face and the subsequent consequences, it is not surprising that rates of mental illness and suicidality among this group far surpass those of the general population (Budge et al., 2013). Among 233 transgender women, 57% reported depression and 42.1% reported anxiety diagnoses (Klemmer et al., 2018). Results from the 2015 U.S.

Transgender Survey revealed that 40% of transgender individuals had attempted suicide in their lifetime, compared to a 4.6% lifetime prevalence of suicide attempts in the general population (James et al., 2016). Results also found 61% of transgender people who survived physical assault had attempted suicide. Having immediate family members who are less affirming or accepting is associated with depression, anxiety, internalizing problems, and externalizing problems in transgender youth (Pariseau et al., 2019). Research also suggests that substance use disorders are more prevalent among this population compared to the general public (Keuroghlian et al., 2015). In a large sample of California middle school and high school students, transgender youth were 2.5 to 4 times more likely to use substances compared to their cisgender peers, depending on the substance (Day et al., 2017). Based on the 2015 U.S. Transgender Survey, substance use among transgender adults is nearly three times the national average (James et al., 2016). Finally, mental health problems can also emerge from gender dysphoria or the significant distress caused by the incongruence between a person's gender identity and their physical attributes (APA, 2013).

Although health disparities among the transgender population undoubtedly exist, research indicates that the healthcare system is not meeting the needs of this community. According to the Centers for Disease Control and Prevention (CDC, 2016), the percentage of transgender people who received a new HIV diagnosis was three times the national average, with transgender women of color at particularly high risk. By and large, transgender people are less likely to be screened for common cancers for a myriad of reasons, including transgender patients not being aware of their risks related to medical and surgical affirmation (Vogel, 2014). For example, it is not common knowledge that the prostate is frequently left intact during a vaginoplasty procedure, warranting continued screening post-surgery (Wichinski, 2015). In terms of cardiovascular health, transgender women on hormone therapy have been found to be at a higher

risk for venous thromboembolism and myocardial infarction (Irwig, 2018). Additionally, there are risks associated with underground cosmetic procedures. Silicone can be commercially obtained and injected into the body to achieve a desired physical shape. If unmonitored, the process is very dangerous and can result in death (Murariu et al., 2015).

Barriers to healthcare for transgender individuals include transportation issues, lack of income, lack of health insurance, mistrust of the healthcare system, and lack of cultural competence by medical providers (Safer et al., 2016). According to Grant et al. (2011), 19% of transgender people report lacking health insurance, including Medicaid. Thus, they face high out-of-pocket costs for transgender specific medical care (Daniel et al., 2015). Those who do hold private and public health plans face exclusions to their care, which may cause a transgender person to seek treatment options through illegal avenues (Committee on Health Care for Underserved Women, 2011).

Interactions with Law Enforcement

Given the discrimination and societal marginalization, transgender individuals are more likely to come into contact with law enforcement and subsequently become incarcerated. Specifically, 16% of transgender adults have been incarcerated, compared to 2.7% of the general population (Grant et al., 2011). Findings further reveal that while one in six transgender Americans have been incarcerated at some point in their lives, for transgender African Americans, the statistic is one in two. Thus, transgender people of color are among the most vulnerable populations due to an interplay between transphobia, racism, and classism (Amnesty International, 2005). Empirical evidence of transgender people's experiences with law enforcement and the criminal justice system has been understudied. However, advocacy groups have illuminated the dangers and injustices faced by transgender people in the legal system using

anecdotal perspectives. Amnesty International, a well-known human rights organization, found that lesbian, gay, bisexual and transgender (LGBT) individuals are more likely to experience negative interactions with criminal justice personnel because of their gender identity and expression (Amnesty International, 2005). For example, transgender women frequently report they are presumed to be prostitutes by police based on their appearance (Amnesty International, 2005). In one study, one-third of Black transgender women and 30% of multiracial transgender women reported an incident where an officer assumed that they were sex workers (James et al., 2016). Although it has been identified that some transgender individuals are involved in sex work as a survival behavior, comparisons to other sex workers suggest that transgender sex workers are still arrested and convicted at a higher rate than other sex workers (Stotzer, 2014). This treatment has been given the colloquial name "walking while trans" to call attention to unprompted stops by police (Carpenter & Marshall, 2017). Transgender individuals are also subject to harassment and invasive searches when their identity documents are inaccurate, meaning their birth name and/or gender marker does not match their chosen name and/or gender expression (Center for American Progress, 2016). In addition to these high rates of unjustified arrest, reports have also illuminated discrimination in case handling and violence perpetrated by law enforcement (Amnesty International, 2005; Bassichis, 2009). According to the 2015 U.S. Transgender Survey, 58% of transgender people who interacted with law enforcement who knew or thought they were transgender reported mistreatment by police, including verbal harassment, being misgendered (i.e., calling a person by the wrong pronouns), physical assault, or sexual assault, such as being forced to engage in sexual activity to prevent arrest (James et al., 2016). Police violence and biased victimization is over three times greater among this population compared to the cisgender population (Chestnut et al., 2012).

Beyond unfair policing strategies, discriminatory laws also increase the likelihood that transgender people will have contact with the criminal justice system (Center for American Progress, 2016; Lydon et al., 2015). According to the Center for HIV Law and Policy, there are six states that may require persons living with HIV to register as a sex offender and 34 states that criminalize HIV exposure (Center for HIV Law and Policy [CHLP], 2020). Further, non-violent drug offenses account for 20% of total incarcerations in the United States (Bureau of Justice, 2016), and drug laws disproportionately impact low-income transgender people of color (Center for American Progress, 2016). Additionally, some cities and states have considered, or in some cases passed what have come to be known as "bathroom bills," laws that punish the use of a restroom that aligns with one's gender identity (Parent & Silva, 2018).

Taken all together, it is evident why transgender communities report a lack of trust in law enforcement, which puts them at an increased risk to not report crime and to not cooperate with police (Moran & Sharpe, 2004; Silver & Miller, 2004). According to the 2015 U.S. Transgender Survey, 57% of all respondents reported feeling uncomfortable seeking police assistance when needed (James et al., 2016). Once transgender individuals reach the correctional environment, discriminatory treatment persists and intensifies.

Treatment While Under Correctional Care

Safety and security are well-known objectives of the jail and prison systems, yet these settings have been identified as being highly dangerous for anyone who does not conform to gender stereotypes (Grant et al., 2011). Jenness and colleagues (2007) found that the prevalence of sexual assault by other incarcerated individuals during the entire incarceration history of a transgender individual was 58.5%, while sexual assault by correctional staff was 13.6%. In another finding, transgender individuals who are incarcerated are ten times as likely to be

sexually assaulted by other individuals who are incarcerated and five times as likely to be sexually assaulted by staff (James et al., 2016). On September 4, 2003, Congress passed the Prison Rape Elimination Act (PREA), which was subsequently signed into law by President George W. Bush. The purpose of this federal law was to protect inmates from sexual victimization. In 2012, federal protections were expanded to transgender individuals who are incarcerated (Au, 2016; Bureau of Justice Assistance, 2017; Prison Rape Elimination Act, 2003). These policies were informed by the strong empirical evidence demonstrating that transgender individuals who are incarcerated are at higher risk of victimization by other inmates and correctional staff while incarcerated than cisgender inmates (Au, 2016; Iyama, 2012).

The jail and prison systems represent one of the most sex-segregated institutions in present day (Sumner and Jennes, 2014). Traditionally, most correctional facilities house inmates based on their assigned sex at birth, however, housing transgender individuals poses a unique challenge. A study of California Department of Corrections facilities found that 77% of transgender people in men's prisons identified as women and lived their lives as women out in the community (Sexton et al., 2010). Under these already difficult conditions, 38% of transgender individuals who are incarcerated experience harassment by jail and prison staff (Grant et al., 2011). In a qualitative study on transgender women's experiences in sex-segregated jails and prisons, one woman noted, "They would do whatever they could to like, dismantle your femininity. Like if you had a wig on, they'll take your wig off. They'd laugh at your clothes, stuff you'd be wearing, they made it a huge point to say 'you're a male,' you know, they pick at you" (White Hughto et al., 2018). The alternative practice to housing by biological sex is to place transgender individuals who are incarcerated in segregation away from the general population in "protective custody" or "administrative segregation," particularly in cases where sexual violence

was perpetrated (Arkles, 2010). It is estimated that 60 to 85% of transgender individuals who are incarcerated are placed under these strict measures (Emmer et al., 2011; Lydon et al., 2015). Although the goal of restrictive housing is to increase safety within a facility, it is believed that the possibility of being moved to restrictive housing serves as a deterrent to reporting sexual assault among transgender inmates (Foster, 2016). Involuntary segregation is also argued to represent a greater threat because this treatment differs little from solitary confinement and serves to punish victims rather than perpetrators. When deprived of normal human interaction, isolation has shown to have negative effects on mental health (Smith, 2006). Furthermore, segregation excludes one from recreation, educational and occupational opportunities (Arkles, 2010). According to PREA, inmates cannot be segregated for more than 30 days, and if an inmate is in protective custody, they must have access to "programs, privileges, education and work opportunities to the extent possible" (Prison Rape Elimination Act, 2003). The U.S. Department of Justice released a special report on the use of restrictive housing in January 2016, noting that inmates who are transgender should not be placed in restrictive housing solely based on their identity, and that housing should be determined on a case-by-case basis (United States Department of Justice, 2016). More generally, a holistic approach is advised to determine housing placement, including input from the inmates themselves (Au, 2016; Bureau of Justice Assistance, 2017; Prison Rape Elimination Act, 2003).

Body searches are another aspect of incarceration that deserves attention when considering transgender needs under correctional care. Strip searches can be traumatic for transgender individuals who are searched by someone of a different gender, especially in instances where it involves their genitals being exposed for the purpose of degradation or harassment (National Center for Transgender Equality, 2019). PREA prohibits searches of

transgender people solely for the purpose of observing or documenting their genital characteristics and requires searches to be conducted professionally, respectfully, and in the least intrusive manner possible (Prison Rape Elimination Act, 2012). Moreover, clauses in PREA encourage the funding of custody staff to undergo appropriate training regarding the medical and mental health care needs of transgender people in their institutions. However, advocates assert that PREA policies are not uniformly implemented and rarely followed in practice (Schwartzapfel, 2016; Thompson et al., 2008). The Prison Policy Initiative conducted a review of transgender policies in 21 states and found that the 85% of these states passed their PREA audit despite not complying to all the guidelines for transgender care. Penalties for noncompliance are often weak or nonexistent if the governor provides "assurance" to the Justice Department that they are working towards compliance (Sontag, 2015). While PREA standards may not be fully carried out in practice in some settings, facilities that are associated with correctional accreditation bodies are required to adhere to more rigorous standards, including those put forth by PREA. For example, facilities must have 100% compliance on mandatory standards and 85-90% compliance on non-mandatory standards to receive accreditation through the National Commission on Correctional Health Care and the American Correctional Association.

With regard to mental health, correctional facilities are in most instances ill-equipped to assess for and treat gender dysphoria. In response to the severe distress experienced from gender dysphoria, some transgender women have gone as far as self-castration, while others have attempted or died by suicide (Maruri, 2011; The Howard League for Penal Reform, 2016). One possible life-saving solution to address gender dysphoria is for individuals to medically transition with gender affirmation surgery. As of 2015, only seven states had policies permitting sex

reassignment surgery for transgender individuals who are incarcerated (Routh et al., 2017). It was not until 2017, that a transgender inmate under the care of the California prison system received sex reassignment surgery (Thompson, 2017). Although an effective and low-cost option, medically necessary hormone therapy to treat an individual's gender dysphoria is also difficult to acquire while incarcerated. In a national study of 129 transgender individuals who are incarcerated who at the time were serving sentences in state Departments of Corrections or the Federal Bureau of Prisons, only 14% of participants reported current cross-sex hormone use (Brown, 2014). Budgetary limitations are often provided as reasoning as to why gender-affirming medical interventions cannot be provided in correctional settings, however, research shows that in actuality, interventions are low-cost and can reduce costs in the long run (Clark et al., 2017). Hormone therapy, such as generic estrogen pills, cost under $15 per month (Consumer Reports, 2008) and can reduce clinically significant psychological distress, depression, suicidality, self-castration and death by suicide (Brown, 2014, 2014; Colizzi et al., 2013). In settings that do have policies in place for continuation of hormones, extensive documentation is required to prove this treatment had previously been ordered by a physician (Brown & McDuffie, 2009; Routh et al., 2017). This can prove difficult for inmates who do not have access to such records, or for those of low socioeconomic status who were accessing “street hormones” (i.e., non-prescribed) prior to incarceration. According to Rotondi et al. (2013), there is a high rate of illicit street hormone use among this population. In a large sample of 433 transgender individuals in Ontario, Canada, an estimated 43% were currently using hormones, and of these, a quarter had at some point obtained hormones from nonmedical sources, including friends/relatives, street/strangers, internet pharmacies, and herbals/supplements (Rotondi et al.,

2013). According to Clark et al (2017), a large percentage of incarcerated transgender individuals are forced to stop their hormone regimen once incarcerated.

More recently, research has begun to document the healthcare experiences of transgender individuals who are incarcerated in correctional facilities. It had been well-documented that transgender individuals carry the burden of negative health outcomes due to their marginalized status (Reisner et al., 2014). Beyond their general health, they may also require access to specialized services, such as gender-affirming medical treatment (e.g., hormone replacement therapy, surgery). Thus, interactions with correctional healthcare providers (e.g., medical doctors, physician assistants, nurses) is also important to examine. Unfortunately, providers oftentimes lack training in transgender-affirming care, further creating barriers to accessing care (Khan, 2011). This reflects a greater structural issue, as the lack of trained providers is in part precipitated by insufficient training in medical school. A 2011 study found the median time dedicated to teaching LGBT-related content among 176 allopathic or osteopathic medical schools in the U.S. and Canada was five hours, with much variation in the quality and content covered. Some of the more common training topics included sexual orientation, HIV, gender identity, sexually transmitted infection, and safer sex. Among the less commonly taught subjects were sex reassignment surgery, body image and transitioning (Obedin-Maliver et al., 2011). In a 2018 survey of 658 New England medical school students, around 80% of respondents stated they felt "not competent" or "somewhat not competent" with the medical treatment of gender and sexual minority patients (Zelin et al., 2018). This can then translate directly to patient care, hindering the ability of medical providers to provide medically competent and sensitive care to transgender patients (Lurie, 2005). A qualitative study of 20 transgender women who were incarcerated within the past five years further supports this notion. Participants reported

incidences of provider transgender bias, provider ambivalence (e.g., long delays accessing transition-related care), provider mistreatment (e.g., using incorrect pronouns), and limited knowledge or experience caring for transgender patients to be barriers to adequate healthcare (White Hughto et al., 2018). Similarly, in a survey of 59 transgender and gender variant individuals inside of or recently released from prison in Pennsylvania, 64% of the respondents believed their medical needs as transgender and gender variant individuals were not taken seriously by medical prison staff (Emmer et al., 2011). For example, one transgender woman in a men's state prison reported being denied mammograms despite the visible presence of breasts and history of breast cancer (Emmer et al., 2011). In another qualitative study of 20 correctional healthcare providers within a correctional facility in New England, researchers identified structural, interpersonal, and individual-level barriers to transgender care. With regard to structural problems, findings mirror past research, citing lack of appropriate training as a barrier despite providers aspiring to provide gender-affirming care. Providers were also limited by restrictive policies and institutional budgets, such as only permitting hormone therapy under certain circumstances. In terms of interpersonal barriers, correctional staff biases toward both healthcare providers and transgender individuals who are incarcerated was a common sentiment. One social worker described himself as being, "a guest in their house," and did not feel correctional staff understood the role of mental health workers. Another social worker referred to an inmate as a transgender woman while speaking to a lieutenant, educating that transgender individuals should be referred to by how they self-identify. The lieutenant, in turn, responded, "Of course you would. We call them 'It.'" Finally, lack of cultural and clinical competency were the primary individual barriers that impeded correctional healthcare workers' ability to provide competent care. For example, one nurse stated that inmates identify as transgender, "Because

they want to stand out...they tend to strut their stuff a lot more and look for more attention more often" (Clark et al., 2017). More recently, research has begun to document sentiments toward transgender people on an individual level.

Correlates of Transphobic Attitudes and Possible Mitigators

It is important to examine beliefs and attitudes on the individual level which contribute to maltreatment of people who are transgender. Hill and Willoughby (2005) defined transphobia as "emotional disgust toward individuals who do not conform to society's gender expectations" (p. 534). Genderism is the cultural belief that gender is predetermined at birth based on biological sex and is fixed over time (Hill, 2002). Thus, anybody who deviates from this status quo is viewed as abnormal. Transphobia can result in prejudice and discrimination directed at those who do not fall within the gender binary. Often there is an irrational fear or misunderstanding around transgenderism, and their very existence is viewed as threatening norms and morals of society (Acker, 2017). These attitudes can develop into covert (e.g., microaggressions, social exclusion) and overt (e.g., sexual assault, physical violence) forms of discrimination (Tarquin & Cooke-Cottone, 2008).

One of the correlates of transphobia that has been found is gender (Acker, 2017; Fisher et al., 2016; Nagoshi et al., 2008; Prunas et al., 2017). In a study of 310 college students, men scored significantly higher than women on a measure of transphobia (Nagoshi et al., 2008). Additionally, hypermasculinity and proneness to aggression were other predictors of transphobia (Nagoshi et al., 2008). According to the Federal Bureau of Prisons (2020), 72% of prison staff members are men. Being that corrections is a male-dominated occupation, this suggests that there is a pervasive culture where feminine expression is not only considered taboo but punished.

Lack of transgender-specific training in most law enforcement and correctional settings

may also contribute to higher levels of transphobia. In a report analyzing policies for the 25 largest police departments, only three departments required new recruits and current staff to receive trainings on transgender interaction policies (National Center for Transgender Equality, 2019). Furthermore, most of these trainings were not created in collaboration with community members in developing or delivering meaningful training (National Center for Transgender Equality, 2019). In terms of general education, lower education attainment is a factor that has been shown to be associated with a range of prejudices against minority groups (Sullivan et al. 1985). However, education levels have not yet been studied as a correlate of transphobia.

According to psychologist Gordon Allport, interpersonal contact is one of the most effective ways to decrease prejudice between majority and minority group members (Allport, 1954; Pettigrew & Tropp, 2006). This is known as the contact hypothesis, or Intergroup Contact Theory (Allport, 1954; Pettigrew & Tropp, 2006). In a meta-analysis on intergroup contact, contact reduces prejudice through the following avenues: (a) by enhancing knowledge about the outgroup, (b) by reducing anxiety about intergroup contact, and (c) by increasing empathy and perspective taking (Pettigrew and Tropp, 2008). For instance, having transgender friends, relatives or acquaintances was found to have a moderating effect on transphobia (Acker, 2017).

Proposed Study

Although research has documented the experiences of transgender individuals who are incarcerated in correctional facilities, no study to date has sought to understand correctional officers' experiences with transgender individuals who are incarcerated from the perspective of officers themselves. By understanding the perspective of correctional officers and their attitudes toward transgender people, this information can inform tailored interventions which aim to

improve standards of care under custody. Based on the extant literature, the following hypotheses for the present study are:

1. Correctional staff members' scores will reflect greater transphobia compared to the normative sample from the Walch et al. (2012) study.
2. Medical staff will exhibit fewer negative attitudes toward the transgender population compared to deputy staff.
3. Higher educational attainment among correctional staff members will be associated with lower levels of transphobia.
4. Male correctional staff members scores will reflect greater transphobia than those of women correctional staff.
5. Correctional staff members who have a transgender family member or friend a will hold fewer negative attitudes toward the transgender population than a staff member who does not have this personal contact.

Method

Procedure

The principal investigator will distribute recruitment information about the study via e-mail. Individuals will receive a brief description of the study, inclusion criteria, and a link to the Qualtrics online survey. Participants will then read the information letter in the survey and provide informed consent. Participants will be asked to complete a demographics questionnaire (Appendix A) followed by a measure of attitudes toward transgender individuals (Appendix B). The survey itself will take approximately 20 minutes to complete. It will be live for two full weeks, with one reminder email halfway through this period. All survey responses will be anonymous, and respondents will not provide identifiable information throughout the course of

this study. No incentive will be offered for participation. The university institutional review board (IRB) and the DSD will approve all study procedures.

Participants

Participants will be correctional staff who provide direct care to inmates, including sworn members (e.g., deputy, sergeant, captain) and medical staff (e.g., nurses, physician assistants, psychiatrists). Sworn positions are affiliated with the DSD, while healthcare staff are employed by Denver Health Hospital and Authority (DHHA). DHHA is a large safety net hospital that addresses the needs of special populations such as persons addicted to substances and the homeless. The hospital is also home to the LGBT Center of Excellence, which offers open and affirming health care to the transgender population. Duties are fulfilled at the two county jails in Denver, Colorado. In order to be eligible for this study, participants must be 21 years and older, as this is one of the qualifications to become a Deputy Sheriff in the state of Colorado. Participants must also be English speaking, as the measure of transphobic attitudes is only offered in English. A power analysis will be conducted to determine the minimum sample size required for the purpose of this study.

Measures

Demographic Questionnaire. The demographic questionnaire (see Appendix A) consists of seven items related to correctional staff characteristics including age, sexual orientation, level of education and years employed.

Attitudes Toward Transgender Individuals. The Attitudes Toward Transgender Individuals Scale (ATTI; Walch et al., 2012) will be used as a measure of transphobic attitudes. The ATTI is a 20-item questionnaire which assesses gender-related stigma, separate from overt forms of discrimination and violence, in the general population (see Appendix B). Responses for

the 20 items range on a 5-point Likert scale including (1) strongly agree, (2) agree, (3) neither agree nor disagree, (4) disagree, and (5) strongly disagree. Examples of items include, "Transgendered individuals should not be allowed to work with children" and "I would feel comfortable if I learned that my neighbor was a transgendered individual." The measure was edited to replace "transgendered" with "transgender" in order to be sensitive to preferred terminology. Findings from the psychometric evaluation of the ATTI scale suggest that this measure is psychometrically sound. Specifically, the instrument demonstrated a single-factor structure, high internal consistency reliability, and evidence of convergent and discriminant construct validity (Walch et al., 2012).

Data Analysis

Quantitative data will be analyzed using Statistical Package for the Social Sciences (SPSS) software (IBM Corp., 2017). In order to examine group differences in attitudes towards transgender individuals, a series of independent t-tests (i.e., paired samples t-test) will be run in order to: 1) compare mean scores on the ATTI between correctional staff members and the normative sample, medical staff, and deputy staff, 2) examine gender differences between male and female correctional staff members, and 3) compare correctional staff members who have a transgender family member or friend versus correctional staff members who do not have this personal contact. Correlational analysis will be conducted to determine whether education level (high school, college, graduate) is correlated with higher ATTI scores. Findings from the study will be presented to the DSD administrators and staff. Findings will also be submitted as manuscript to a peer-reviewed journal (e.g., *The Prison Journal*), as well as disseminated at local or national correctional conferences (e.g., National Conference on Correctional Health Care).

Discussion

Literature has revealed the overrepresentation of transgender people in jails and prisons, and their high likelihood of being victims of discrimination, harassment, and violence in these settings. Unfortunately, disrespectful and unfair treatment are in many instances committed by the very people who are expected to maintain the safety of the institution – correctional staff. Research has previously examined the experiences of transgender individuals who are incarcerated in correctional facilities; however, no study to date has sought to understand correctional officers' attitudes toward inmates who are transgender. Results from the proposed study are predicted to reveal that transphobic attitudes in correctional officers are higher than the general population. By having this information, it will provide rationale for tailored interventions that foster more understanding of and sensitivity toward this vulnerable population. It is important to note that transgender advocates, such as the National Center for Transgender Equality and The Fenway Institute, have pushed for the widespread enactment of transgender policies for many years.

Implications for Policy

Correctional facilities have an obligation to ensure the safety and well-being of individuals in their facility, irrespective of personal beliefs. The purpose of correctional policies regarding the care of transgender individuals who are incarcerated is to protect them from violence and discrimination. Transgender policy has historically been combined with gay and lesbian policies; however, sexual orientation protections do not sufficiently cover transgender people (Taylor et al., 2012). Policy development and implementation requires several key components in order to be effective (The Fenway Institute, 2019). This includes leadership support for inclusive and fair treatment, staff involvement, outside expertise, staff education, and enforcement and accountability. Furthermore, The Fenway Institute emphasizes that policies

cannot be uniformly adopted by correctional facilities across jurisdictions given stark differences in current practices. An assessment of institutional culture, policies, attitude, and knowledge of transgender issues is recommended. The following is a list of minimum recommendations to be incorporated into correctional polity and procedure.

The preference of transgender people should be considered when determining housing. In recent years, transgender advocates have called for jail/prison placement on the gender with which the individual identifies and where they will be the safest (Smith, 2015). Cook County, San Francisco, and Washington, DC, are among several jurisdictions that have created alternative jail housing policies (Dodson, 2018). Organizations should implement a committee to review cases of transgender individuals who are incarcerated to determine where they are housed, as well as how they are dressed and searched, and at least one committee member should be experienced in transgender issues. Denver Sheriff's Department, for example, has a Transgender Review Committee which consists of a sergeant, facility nurse or provider, and behavioral health specialist. Committee members are required to make determinations within 72 hours of the inmate being booked into custody (Denver Sheriffs Department, 2012). During this intake period, inmates who are transgender should be screened for mental health issues (e.g., depression and suicide, anxiety, trauma and posttraumatic stress) and sexually transmitted infections, including HIV. Further, inmates who are transgender should not be placed in segregation solely based on their gender identity or status. Protective custody should only be used as a final course of action and should last for the least amount of time possible. Should protective custody be utilized, inmates should be overseen by medical staff and have access to recreation, educational and occupational opportunities.

A nondiscrimination statement should be adopted into the policy of all corrections departments and facilities. For instance, the Vermont Department of Corrections (Policy No. 432.01) has a strong model for other organizations, including zero-tolerance policies prohibiting discrimination or harassment on the basis of sexual orientation and/or gender identity in its facilities. Staff members who exhibit noncompliance or who lack competence in following these policies should be provided with additional training, supervision, and other forms of tailored support. Persistent violations should result in disciplining or termination when necessary.

A policy should also be adopted by all corrections department and facilities around use of affirming language. It should be the expectation that staff use affirming language when interacting with inmates and other staff, regardless of whether the inmate has undergone a legal name change or gender-affirming medical treatment. This includes the use of preferred pronouns, use of gender-neutral pronouns, such as "they" when preferred pronoun is unknown, and use of preferred name. The use of demeaning language, such as the use of common slurs, should not be tolerated.

Inmates who are transgender should have access to hormone therapy, regardless of prior documentation of hormone use. Inmates who are initiating hormone therapy should be made aware of the risks and benefits of this treatment in order to provide informed consent. Gender affirming surgery should be considered on a case-by-case basis and provided when determined to be medically necessary by a health care provider. Treatment should generally be consistent with The World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al., 2012).

All corrections departments and facilities should provide training on transgender care to correctional staff to increase cultural competence. This includes current staff and new

recruits. Training should be delivered by a professional with expertise in this area. Health care staff should undergo additional training to provide gender-affirming health care, such as how to initiate and monitor hormone therapy.

Correctional facilities should have an ethical and legal obligation to abide by the standards put forth by PREA. As stated by the National PREA Resource Center,

> "All confinement facilities covered under PREA standards must be audited at least once during every three-year audit cycle to be considered compliant with the PREA standards, with at least one third of each facility type operated by an agency, or private organization on behalf of an agency, audited each year of the three-year audit cycle" (National PREA Resource Center, n.d., para. 2).

It was previously highlighted that the vast majority of states pass their PREA audit, despite not complying to all the guidelines for transgender care. Thus, it is proposed that when governors submit assurances for PREA compliance, they should also provide measurable steps they will take to ensure compliance within a reasonable yet firm timeframe. Otherwise, states should face financial penalties to guarantee accountability.

Implications for Training

Transgender-specific cultural competency training may be an effective way to increase awareness and knowledge and decrease bias and discrimination among correctional staff. Gender affirming training in correctional settings is shown to be effective. For instance, three months after an LGBT training was given to health care staff at 12 facilities in the New York City correctional system, patient complaints decreased by over 50% (Jaffer et al., 2016). The content of the training consisted of LGBT discrimination and marginalization, awareness and sensitivity to LGBT issues and myths, and barriers to care for LGBT patients. Although there is no widely

accepted curriculum to train health care providers or correctional staff about the transgender population, Knaak et al., (2014) identified the following key ingredients of anti-stigma interventions to improve attitudes in target groups such as health care providers: (1) Include multiple forms of social contact such as by providing personal testimonies of the stigmatized group, (2) Foster behavior change by teaching skills so people know what to say and do when interacting with the stigmatized group, (3) Challenge myths regarding the stigmatized group, and (4) Select a passionate facilitator who employs a person-centered approach and sets the tone for the training. Thus, training should be informed by firsthand accounts of transgender individuals who are incarcerated and their experiences with correctional staff, such as being mis-gendered, being expected to educate others on what is means to be transgender and being denied female hygiene and commissary items. Training for correctional staff specifically might include but is not limited to:

- An overview of transgender history, which includes the historical stigmatization and pathologizing of the transgender community that has made it difficult for them to trust and rely on the helping professions.
- Encourage participants to consider the messages they received about gender while growing up. Use of current research may aid in debunking commonly held stereotypes.
- Education on the gender spectrum including an overview of definitions and terminology, with an emphasis on problematic terms to avoid.
- Education on gender dysphoria and negative outcomes associated with untreated gender dysphoria. Common examples of mistreatment in correctional facilities should be highlighted.

- Review of PREA guidelines and organizational non-discrimination policies.

Providing transgender-specific cultural competency training will not be met without challenge (Miles-Johnson, 2016). Israel and colleagues (2017) qualitatively examined reactions of 120 law enforcement officers to an LGBTQ diversity training, with responses varying from resistance to receptiveness. Examples of resistance included 1) believing that law enforcement was already doing a good job and no additional training was needed, 2) believing that LGBTQ people want special treatment and allege discrimination to get out of trouble, and 3) questioning statistics about law enforcement. Resistance was also captured in the form of nonverbal behavior during training, such as low engagement, joking/laughing during the training and discomfort during role-plays. Regarding training receptiveness, law enforcement officers asked clarifying questions, expressed empathy for the LGBTQ community, and helped other law enforcement officers understand training material/LGBTQ oppression. By having this information, it helps training facilitators better prepare to respond to anticipated challenges. For example, it may be helpful to clarify "ground rules" and explain training objectives prior to facilitation. Israel et al. (2017) also highlighted the importance of training facilitators understanding the organizational culture and larger sociopolitical context when providing this training.

Future Directions

The present paper advocates for systematic training to improve cultural competence in correctional officers. Only one study to date has designed and tested a group-based, transgender health training for correctional settings. This study, however, targeted their training to correctional health care providers (White Hughto & Clark, 2019). It will be necessary for future studies to measure the efficacy of this training using pre-post, longitudinal data.

Historically, transgender individuals have suffered mistreatment and discrimination on a wide scale and consequently have faced significant challenges in getting their basic needs met. Dissemination and implementation of research has historically been a problem in academia, so while research to understand the unique needs of transgender people is growing, policy and practice is lagging behind. In the future, improvements need to be made in the areas of fostering societal understanding of the trans experience, equal treatment between transgender people and other populations, and access to quality health care. Moreover, much work is needed to establish safety, security and justice for transgender people in the criminal justice system, from point of contact (e.g., decriminalization of sex work) to the transition from jail back into the community (e.g., connecting individuals to equitable employment, providing nonmedical services in conjunction with primary care).

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APPENDIX A: DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions to help us understand your background and position at Denver Sheriff Department and Denver Health.

1. What is your age?

2. What is your sexual orientation?
    a. Heterosexual/straight
    b. Gay or lesbian
    c. Bisexual
    d. Asexual
    e. Pansexual
    f. Other (please describe): _____

3. What is your gender identity?
    a. Woman
    b. Man
    c. Non-binary/gender non-conforming
    d. Other (please describe): _____

4. What is your race/ethnicity?
    a. White or European American
    b. Black or African-American
    c. Hispanic or Latinx
    d. Asian
    e. Native Hawaiian or Other Pacific Islander
    f. Middle Eastern or North African
    g. American Indian or Alaska Native
    h. Other (Please describe): _____

5. What is your highest level of education?
    a. Less than high school diploma
    b. High school diploma / GED
    c. Some college or associate degree / trade degree
    d. Bachelor's degree
    e. Master's degree or higher (e.g., Ph.D., M.D.)

6. How many years have you been employed as correctional staff through Denver Health or the Denver Sheriffs Department?

7. Do you have a friend or a family member who identifies as transgender?
    a. Yes
    b. No
    c. Don’t know

APPENDIX B: ATTITUDES TOWARD TRANSGENDERED INDIVIDUALS SCALE

Attitudes Toward Transgendered Individuals Scale

Transgendered people are those whose gender identity (sense of oneself as a man or a woman) or gender expression (expression of oneself as male or female in behavior, manner, and/or dress) differs from conventional expectations for their physical sex. Transgendered people include pre-operative, post-operative, and non-operative transsexuals who feel that they were born into the wrong physical sex as well as those who crossdress to express an inner cross-gender identity.

This questionnaire is designed to measure the way you feel about working or associating with transgendered individuals. It is not a test, so there are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1=Strongly agree 2=Agree 3=Neither agree nor disagree 4=Disagree 5=Strongly disagree

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____ 1. It would be beneficial to society to recognize transgenderism as normal.

____ 2. Transgender individuals should not be allowed to work with children.

____ 3. Transgenderism is immoral.

____ 4. All transgender bars should be closed down.

____ 5. Transgender individuals are a viable part of our society.

____ 6. Transgenderism is a sin.

____ 7. Transgenderism endangers the institution of the family.

____ 8. Transgender individuals should be accepted completely into our society.

____ 9. Transgender individuals should be barred from the teaching profession.

____ 10. There should be no restrictions on transgenderism.

____ 11. I avoid transgender individuals whenever possible.

____ 12. I would feel comfortable working closely with a transgender individual.

____ 13. I would enjoy attending social functions at which transgender individuals were present.

____ 14. I would feel comfortable if I learned that my neighbor was a transgender individual.

____ 15. Transgender individuals should not be allowed to cross dress in public.

____ 16. I would like to have friends who are transgender individuals.

____ 17. I would feel comfortable if I learned that my best friend was a transgender individual.

____ 18. I would feel uncomfortable if a close family member became romantically involved with a transgender individual.

____ 19. Transgender individuals are really just closeted gays.

____ 20. Romantic partners of transgender individuals should seek psychological treatment.